

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2011
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 901 MACARTHUR BLVD MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00089353 Substantiated: No deficiencies cited.</p> <p>Date: 11/3/11</p> <p>Facility Number: 005106</p> <p>Surveyor: Jacqueline Brown, R.N. Public Health Nurse Surveyor</p> <p>Community Hospital is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 11/29/11</p>	S 000		

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

RMC011

If continuation sheet 1 of 1